DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: RBRVS USERS:
Anesthesiologists
Advanced Registered Nurse Practitioners
Ophthalmologists
Optometrists
Psychiatrists
Emergency Physicians
Nurse Anesthetists
Physicians
Physician Clinics
Registered Nurse First Assistants
Family Planning Clinics
Federally Qualified Health Centers
Health Departments
Healthy Kids/EPSDT Clinics
Laboratories
Managed Care Carriers
Podiatrists
Radiologists
Regional Administrators
CSO Administrators

Memorandum No.: 01-12 MAA
Issued: April 15, 2001

For Information Contact:
Toll Free: 1-800-562-6188

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Updates to Physician-Related Services (RBRVS) Billing Instructions**

The Medical Assistance Administration (MAA) will implement the changes discussed in this numbered memorandum to the *Physician-Related Services (RBRVS) Billing Instructions* **effective with dates of service as noted**.

I. Immunizations - Children

Pneumococcal vaccine PCV7 (CPT code 90669) - Formerly known as Prevnar, this vaccine will be added to those immunizations that are available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program, and distributed through the Department of Health (DOH).

Effective for dates of service on or after May 1, 2001, physicians may no longer bill MAA directly for this code. Vaccines obtained from DOH must be billed using the appropriate procedure code with modifier 1H (e.g. 90669-1H). MAA reimburses an administration fee (up to $5.00) for DOH-supplied vaccines.

When immunization materials for PCV7 are obtained from DOH, prior authorization will no longer be required from MAA.

II. Visual Function Screening

Visual function screening (CPT code 99172) – Effective for dates of service on or after May 1, 2001, MAA will no longer cover this service. MAA has learned that this code was intended to be used as part of a pre-employment screening examination, which is not considered medically necessary. MAA only covers procedures that are considered medically necessary.

III. Maximum Allowable Fees for New 2001 Oncology Drugs

Retroactive to dates of service on or after January 1, 2001, the following maximum allowable fees were established for the new 2001 CPT codes for oncology drugs:

HCPCS Code	Description	Maximum Allowable Fee
J9160	Denileukin diftitox, 300 mcg	$999.88
J9180	Epirubicin hydrochloride, 50 mg	$623.44

IV. Intra-Articular Injections

Sodium hyaluronate (J7315) and Hylan G-F 20 (J7320) - Retroactive to dates of service on or after October 1, 2000, MAA began allowing rheumatologists, as well as orthopedic surgeons, to bill these injections.

V. Intrauterine Devices

HCPCS code J7300 and state-unique code 9911M - Retroactive to dates of service on or after November 1, 2000, the fees for intrauterine devices were increased to $299.00. If a claim has already been processed for one of these devices for dates of service on or after November 1, 2000, the provider must submit an adjustment form in order to receive additional reimbursement.

Beginning with dates of service on or after March 1, 2001, MAA began paying for the intrauterine device, Mirena, using the following state-unique code:

State-Unique Code	Description	Maximum Allowable Fee
9913M	Mirena intrauterine device	$351.55

VI. MRI/MRA

As detailed in Section G of the July 2000 *Physician-Related Services (RBRVS) Billing Instructions*, all MRIs require Expedited Prior Authorization (EPA). The new 2001 CPT codes for MRIs are included in this requirement. The following chart lists the three-digit numerical code of the diagnostic condition, procedure, or service that meets the EPA criteria. This three-digit code should be **added to the end of 870000 to create a 9-digit EPA number**. Refer to pages G6-G9 of the *Physician-Related Services Billing Instructions* for a full explanation of the criteria represented by each three-digit code.

CPT Code	Three-Digit Code Choices	CPT Code	Three-Digit Code Choices
70542	390	70543	390
70544	301-309 or 390	70545	301-390 or 390
70546	301-309 or 390	70547	390
70548	390	70549	390
71551	390	71552	390
72195	341-342 or 390	72197	341-342 or 390
73218	361 or 390	73219	361 or 390
73222	361 or 390	73223	361 or 390
73718	371 or 390	73719	371 or 390
73722	371 or 390	73723	371 or 390
74182	381 or 390	74183	381 or 390

VII. Synagis

Synagis (CPT code 90378) - MAA covers this immune globulin only after prior authorization has been obtained. The following payment levels have been established for Synagis:

Description*	Maximum Allowable Fee
Synagis, 50 mg	$576.00
Synagis, 100 mg	$1,140.00
Synagis, 150 mg	$1,716.00
Synagis, 200 mg	$2,280.00

Requests for authorization must be submitted in writing to:

Division of Health Services Quality Support
Quality Fee-for-Service Program, Synagis Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

The instructions for billing Synagis detailed above replace the billing instructions for Synagis in Section C of the July 2000 *Physician-Related Services (RBRVS) Billing Instructions*.

To obtain this numbered memorandum and fee schedules electronically go to MAA's website at http://maa.dshs.wa.gov.